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Research Article

# A COMPARATIVE STUDY TO ASSESS KNOWLEDGE REGARDING CHIRANJEEVI YOJANA AMONG SELECTED RURAL AND URBAN COMMUNITY SIKAR.

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**ABSTRACT**

Health schemes are crucial for ensuring equitable access to healthcare. The Chiranjeevi Yojana, launched in Rajasthan, India, aims to provide comprehensive health coverage to citizens. his study assesses knowledge levels regarding the Chiranjeevi Yojana among rural and urban communities in Sikar, Rajasthan. A quantitative approach was employed, utilizing a non-experimental comparative research design. A sample of 100 participants, 50 from rural and 50 from urban areas in Sikar, was selected using convenient sampling. For instance, in the rural community, the majority (54%) demonstrated moderately adequate knowledge about the Chiranjeevi Yojana, while 32% exhibited inadequate knowledge, and only 14% had adequate knowledge. Conversely, in the urban community, a larger proportion (56%) showed moderately adequate knowledge, with 28% displaying adequate knowledge and 16% having inadequate knowledge. Notably, the percentage of individuals with adequate knowledge in the urban community (28%) surpassed that of the rural community (14%). Significant associations were found between knowledge of the Chiranjeevi Yojana and demographic variables such as gender, education, occupation, and family income in both rural and urban communities. While age and source of information showed non-significant associations, disparities in knowledge levels were observed between rural and urban residents, with urban dwellers exhibiting higher awareness scores. The study highlights the importance of considering socio-demographic factors when designing health education programs. Tailored interventions are needed to bridge the gap in healthcare scheme awareness between rural and urban populations.

**KEYWORDS:** Chiranjeevi Yojana, healthcare scheme, awareness, rural, urban, Rajasthan.

## INTRODUCTION

Health is important for us. Health is a fundamental right of individuals. It is the responsibility of both the government and individuals to prioritize their health. The Government of India has an overall budget of 98,461 crore rupees for year 2024.[1] The Government of India launches various schemes at both the state and central levels. At the central level, Ayushman Bharat Yojna was launched on 23rd September 2018.[2] In Rajasthan, the Chiranjeevi Yojna was launched on 1st May 2021.[3]

The Chief Minister Chiranjeevi Health Insurance Scheme, launched by the Government of Rajasthan, aims to provide universal health coverage in the state, fulfilling the vision of Mahatma Gandhi to alleviate suffering and ensure healthcare access for all. This initiative, announced in the 2021-22 budget, extends quality medical services to citizens, reducing the burden of medical expenses, particularly for serious illnesses. Building on past successes such as free medicine and testing schemes, the Rajasthan government's commitment to healthcare accessibility underscores its proactive stance in improving public health.[4]

The Chiranjeevi Health Insurance Scheme endeavors to diminish out-of-pocket health expenses for eligible families while offering specialized medical services through both government and private hospitals. The scheme covers a comprehensive range of medical treatments, including pre and post-hospitalization costs, consultation fees, and diagnostic tests. Notably, the scheme's recent expansion, increasing coverage from 10 to 25 lakh per family, highlights the government's dedication to enhancing healthcare accessibility and affordability for all residents.[5]

Despite governmental efforts to improve healthcare access, there remains a significant gap in public

awareness and utilization of schemes such as Chiranjeevi Yojana. This study addresses the imperative to assess public knowledge and understanding of the scheme, crucial for ensuring its effective implementation and impact. Given the precarious state of healthcare infrastructure and high out-of-pocket expenses faced by Indian households, comprehensive health insurance schemes like Chiranjeevi Yojana play a pivotal role in safeguarding public health and mitigating financial strain. Understanding the awareness levels and barriers to scheme utilization is fundamental for policymakers in refining strategies and maximizing the scheme's reach and impact across rural and urban populations in Sikar. Every person has knowledge about health scheme.

## METHODOLOGY

**Research Approach:** The study employed a quantitative research approach to assess knowledge of the Chiranjeevi Yojna among rural and urban communities in Sikar, aligning with positivist and deterministic principles for systematic data collection and analysis.

**Research Design:** A Non-Experimental Comparative Research Design was employed to assess knowledge of the Chiranjeevi Yojna among rural and urban communities in Sikar.

**Research Population:** The research population comprised selected rural and urban community of sikar present at study.

**Research Sample**: A total sample size of 100 participants, comprising 50 from rural and 50 from urban communities in Sikar, was selected using a non-probability convenient sampling technique.

**Setting of Study:** The study was conducted at Palsana Village (rural community), Tilak nagar (urban community) at Sikar.

**Data Collection Tools**

To gather data on knowledge regarding Chiranjeevi Yojna among the rural and urban communities in Sikar, a structured questionnaire schedule was utilized as the primary data collection tool. This questionnaire included sections on various aspects of the Chiranjeevi Yojna, aiming to comprehensively assess participants' understanding of the scheme's details and benefits.

**Data Analysis:** Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize socio-demographic characteristics and knowledge scores among the study participants. Inferential statistics, such as chi-square tests, were employed to explore associations between knowledge level and demographic variables. All data analysis was conducted using appropriate statistical software.

## RESULT

**Table 1: Demographic Characteristics.**

| SL No | Demographic Variables | Rural (F) | Rural (%) | Urban (F) | Urban (%) |
|---|---|---|---|---|---|
| **1** | Age in years | | | | |
| | 20 - 24 years | 10 | 20 | 13 | 26 |
| | 25 - 29 years | 10 | 20 | 14 | 28 |
| | 30 - 34 years | 15 | 30 | 14 | 28 |
| | 35 - 40 years | 15 | 30 | 9 | 18 |
| **2** | Gender | | | | |
| | Male | 29 | 58 | 31 | 62 |
| | Female | 21 | 42 | 19 | 38 |
| **3** | Level of education | | | | |
| | No formal education | 4 | 8 | 2 | 4 |
| | Primary education | 14 | 28 | 0 | 0 |
| | Secondary education | 8 | 16 | 10 | 20 |
| | Higher school | 13 | 26 | 20 | 40 |
| | Graduate and above | 11 | 22 | 18 | 36 |
| **4** | Occupation | | | | |
| | No occupation | 22 | 44 | 13 | 26 |
| | Labor | 8 | 16 | 14 | 28 |
| | Business | 11 | 22 | 11 | 22 |
| | Job | 9 | 18 | 12 | 24 |
| **5** | Family monthly income | | | | |
| | 10,000 - 20,000 | 27 | 54 | 16 | 32 |
| | 20,001 - 30,000 | 12 | 24 | 12 | 24 |
| | 30,001 - 40,000 | 7 | 14 | 11 | 22 |
| | >40,000 | 4 | 8 | 11 | 22 |
| **6** | Source of Information | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | Health care worker | 10 | 20 | 5 | 10 |
| | TV/Radio/Newspaper | 17 | 34 | 28 | 56 |
| | Colleague | 19 | 38 | 10 | 20 |
| | Teacher | 4 | 8 | 7 | 14 |

Table 1 demographic characteristics reveals a balanced age distribution in both rural and urban communities, with notable proportions across different age groups. In terms of gender, there is a slightly higher representation of males in both rural (58%) and urban (62%) areas. Education levels vary, with a significant percentage having completed secondary education or higher, particularly in the urban community (40%). The distribution of occupations shows a mix, with a considerable portion engaged in various occupations such as business and labor. Family monthly income ranges vary, with a substantial proportion falling within the 10,000 - 20,000 Rs bracket for both rural (54%) and urban (32%) areas. Primary sources of information include healthcare workers, TV/radio/newspapers, colleagues, and teachers.

**Table 2: Association Between Knowledge Regarding Chiranjeevi Yojana and Selected Demographic Variables for both Rural and Urban Communities.**

| Demographic Variable | Rural Community | | | Urban Community | | |
|---|---|---|---|---|---|---|
| | Chi-square | df | Significance | Chi-square | df | Significance |
| **Age in Years** | 12.224 | 6 | NS | 2.929 | 6 | NS |
| **Gender** | 10.535 | 2 | S | 15.741 | 2 | S |
| **Level of Education** | 40.539 | 8 | S | 16.260 | 6 | S |
| **Occupation** | 31.727 | 6 | S | 28.325 | 6 | S |
| **Family Monthly Income** | 25.553 | 6 | S | 9.892 | 6 | NS |
| **Source of Information** | 2.954 | 6 | NS | 10.019 | 6 | NS |

**Table 2.** In both rural and urban communities, significant associations are observed between knowledge of the Chiranjeevi Yojana and gender, level of education, occupation, and family monthly income. However, age distribution and the source of information show non-significant associations in both communities. This suggests that demographic factors such as gender, education, occupation, and income may influence awareness levels regarding the Chiranjeevi Yojana.

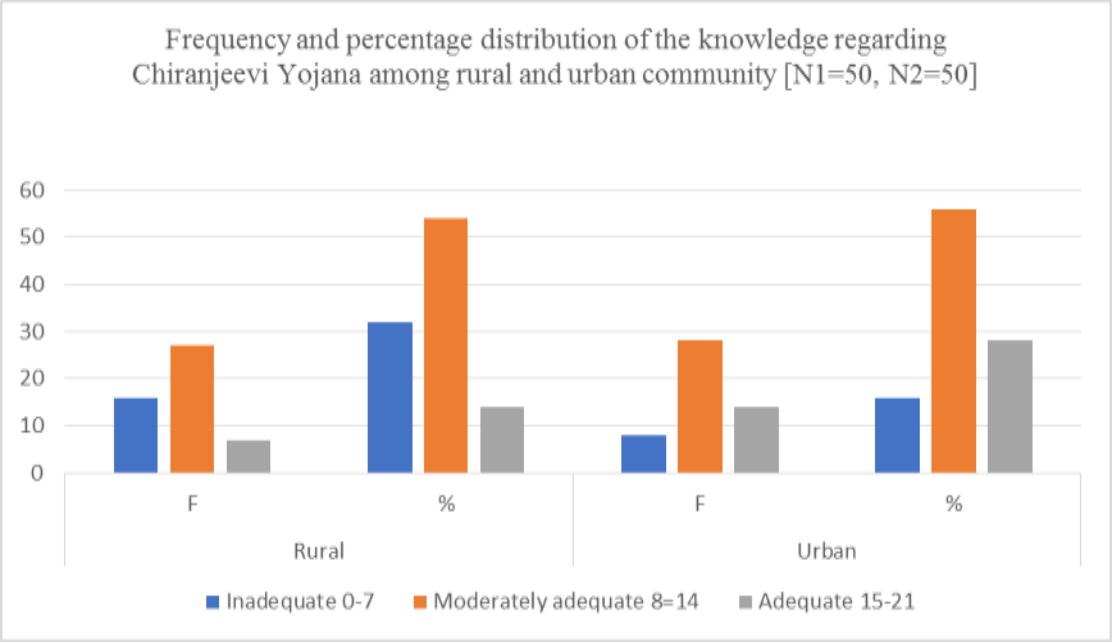


**Figure 9: Bar Graph Showing Percentage Distribution Of Level Of Knowledge Regarding Chiranjeevi Yojana Among Rural And Urban Community.**

In the rural community, the majority (54%) demonstrated moderately adequate knowledge about the Chiranjeevi Yojana, while 32% exhibited inadequate knowledge, and only 14% had adequate knowledge. Conversely, in the urban community, a larger proportion (56%) showed moderately adequate knowledge, with 28% displaying adequate knowledge and 16% having inadequate knowledge. Notably, the percentage of individuals with adequate knowledge in the urban community (28%) surpassed that of the rural community (14%).

**Table 3: Comparing the Knowledge Regarding Chiranjeevi Yojana Between Rural and Urban Community [n1=50, n2=50].**

| Knowledge Level | Mean | Mean % | Mean Difference | SD | Df | 't' value | p value | Result |
|---|---|---|---|---|---|---|---|---|
| **Rural** | 10.14 | 48.28% | 1.86 (8.86%) | 2.85 | 98 | 3.196 | **0.002** | **S** |
| **Urban** | **12** | **57.14%** | | **2.96** | | | | |

S = P value significant at 0.05 level of significance

**Table 3.** Comparing knowledge levels between rural and urban communities, urban residents demonstrate higher knowledge scores (mean score: 12, mean percentage: 57.14%) compared to rural residents (mean score: 10.14, mean percentage: 48.28%). The difference in mean knowledge scores between rural and urban communities is statistically significant (t-value = 3.196, $p < 0.05$), indicating disparities in awareness and understanding of the Chiranjeevi Yojana between these populations.

## DISCUSSION

Based on our key findings, it's evident that there's a significant association between socio-demographic variables and knowledge regarding the Chiranjeevi Yojana in both rural and urban communities. For instance, in the rural community, the majority of individuals with higher education levels and those from higher income brackets demonstrated better awareness of the scheme. Similarly, in urban areas, gender, education, occupation, and income significantly influenced knowledge levels. This underscores the importance of considering socio-demographic factors when designing public health education programs. Supporting this interpretation, our analysis revealed a statistically significant difference in mean knowledge scores between rural and urban communities, with urban residents displaying higher awareness levels. This suggests that tailored educational interventions may be necessary to address disparities in healthcare scheme awareness across different demographic groups.

Comparing our findings with previous studies, our study aligns with research conducted in similar contexts. For example, a study conducted by Bhimani et al., (2013) found that education level was a significant predictor of awareness regarding healthcare schemes, consistent with our results.[6] Additionally, Sharma et al., (2023) observed gender disparities in scheme awareness, mirroring our findings in both rural and urban settings.[7] However, our study diverges from previous research in terms of the influence of age and source of information on knowledge levels, highlighting the need for context-specific analyses. Nevertheless, the overall consistency in findings across multiple studies underscores the robustness of our results and their relevance for informing healthcare policy and education efforts.

Our study's strengths lie in its comprehensive examination of various socio-demographic factors and their associations with healthcare scheme awareness. By including both rural and urban communities, we captured a diverse range of perspectives, enhancing the generalizability of our findings. However, limitations include the reliance on self-reported data, which may introduce response bias, and the cross-sectional design, which precludes causal inference. Additionally, unexpected findings, such as the non-significant association between age and knowledge levels, warrant further investigation to explore potential underlying factors.

## CONCLUSION

Our study aimed to investigate the association between socio-demographic variables and knowledge regarding the Chiranjeevi Yojana, shedding light on disparities in healthcare scheme awareness across different population groups. The significance of our findings lies in their implications for designing targeted health education interventions and policy initiatives aimed at improving healthcare access and equity. Moving forward, future research could explore the long-term impact of such interventions and investigate additional factors influencing healthcare scheme awareness to further refine public health education strategies.

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